

MILESTONES OF RECOVERY SCALE (MORS)

EXECUTIVE SUMMARY

The recovery based transformation is clearly upon us. It seems like every week the proponents of this movement throw something new at us on top of our already too large work loads. Sometimes they are things that seem so obvious, like helping people get housing and jobs, that we respond, “We’re already doing that *when we have the resources*,” and sometimes they are things so strange and even potentially dangerous, like hiring a staff who has a mental illness, sharing restrooms, and promoting medication choice instead of medication compliance, that we feel like throwing them out entirely. Sometimes they are promoting values like hope, healing, authority, and community that seem strangely naïve and simple. Sometimes they bring touching client stories of gratitude for our help and make it seem like we may be onto something important. Sometimes they bring things like clinic restructuring and Wellness Centers that, like it or not, directly impact our work and can’t be ignored or waited out. The Milestones of Recovery Scale (MORS) is yet another product of the recovery transformation being thrust upon us.

Before we just throw the MORS into the pot and stir it around with everything else, it may help to give include some context, some explanation, and some instructions.

Measuring how well real people are doing is hard to do and hard to apply. We all know statistics can be misleading and slanted. On the other hand, we also know that when we keep track of how we’re doing, it’s more likely we can improve our work and convince other people our work is worthwhile. For the most part, mental health services have chosen not to measure outcomes and, as a result, we don’t really know how well we’re doing and outsiders don’t think we do much. People don’t come in for services because they think we don’t do anything anyway. Legislators cut our budgets. Chart audits get more and more extensive partly because they think we’re billing for doing nothing.

The recovery transformation believes that we are doing important work and achieving better results than anyone, including ourselves, believes. We think we’d get more community support, more hopeful clients and staff, and more money if we could measure how we are doing.

We’ve all had experiences where statistics have been misused by administrators to pressure us. We’ve all seen colleagues distort their statistics to look better than us or do less work. The MORS can be misused just like any other measurement tool.

When our mental health system does measure anything (usually in pharmaceutical research and university settings) it tends to use symptom checklists like PANS, BPRS, and Depression and Anxiety inventories that we vaguely remember from school. These scales are designed to measure if an illness is being treated successfully. One of the fundamental shifts in the recovery movement is to move from focusing on treating illnesses to focusing on helping people with illnesses have better lives. Therefore, the first outcome tools created by the recovery movement were Quality of Life outcome scales instead of symptom relief scales.

It turns out that some Quality of Life outcomes (like housing situation, employment, jailing, education, and finances) are relatively easy to measure and some Quality of Life outcomes (like satisfaction with life, self esteem, social life and connectedness, disruption from substance abuse, and family relationships) are relatively difficult to measure. As time has gone on, we have increasingly emphasized those things that are easy to measure and dropped those that are not.

This makes less work for you while keeping enough important achievements to be impressive. The AB2034 program grew into the MHSA by emphasizing just four outcomes that were relatively easy to measure – homelessness, jailing, hospitalization, and employment.

The MORS is not a Quality of Life scale. It is a “Where is someone in the process” scale.

The major “Where is someone in the process” scale presently used (and regularly misused) is the Global Assessment of Functioning (GAF) scale. This scale has built into it the major premise of the medical model: As symptoms are reduced, life is less disrupted and function increases. The recovery movement has found that this premise is only sometimes and somewhat true. We all know clients who, even after their symptoms are improved, still have poor function and a crippled life. We also all know clients who amaze us by functioning well and building a meaningful life even while experiencing severe symptoms.

The recovery movement would like to have a simple scale that measures where people are in the recovery process instead of where their illness is in the treatment process. That turns out to be incredibly difficult. After all, recovery is a strikingly individualized process. It is fundamentally a subjective process that belongs to the individual who is recovering. It encompasses processes incredibly hard to observe or measure. We persisted anyway.

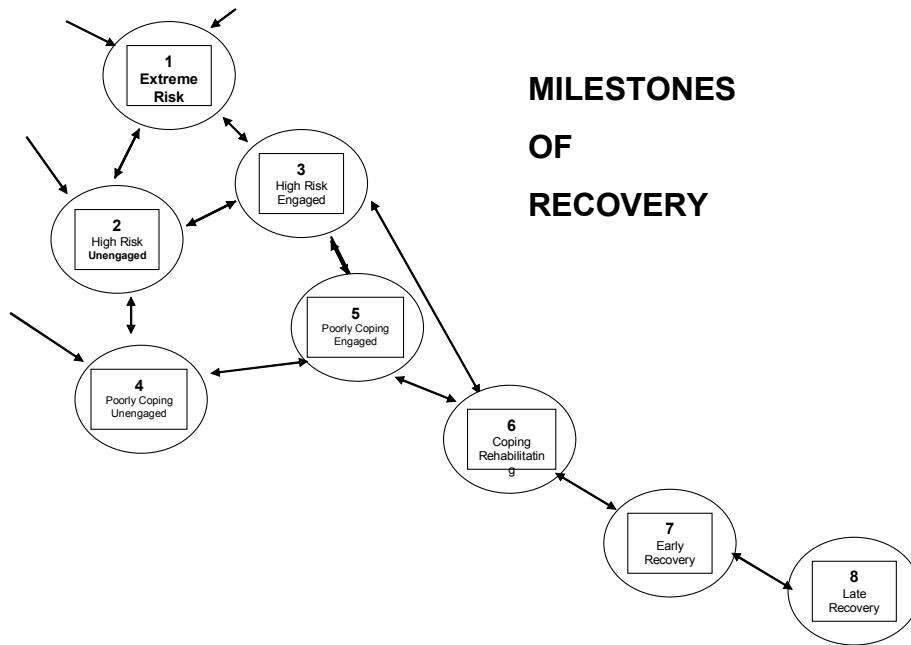
The MORS scale began when over 100 consumers, staff, program directors, and family members tried to identify important indicators of recovery. (Note an important step there. We moved from trying to measure recovery itself to trying to measure indicators of recovery; or, to use more statistical language, the correlates of recovery. We’re not too bothered by this shift. Think about it. We don’t actually measure the temperature outside. We measure the expansion of mercury in a small tube which correlates with temperature. Almost all measurements are like that.)

Not surprisingly we came up with hundreds of items ranging from self esteem to avoiding conservatorship to taking medications. This time, instead of choosing items that were the easiest to measure, we tried to see if there were just a few items that would by themselves correlate with recovery so we could design a very short scale. We also wanted the items to describe properties of the person themselves – not of their illness or their treatment. Three items emerged: Risk, Engagement, and Skills and Supports.

These items aren’t obscure. They are already part of our daily thinking when we work with clients. They make sense to us: We’d expect someone who is recovering to have less and less risk of damage in their lives. We’d expect them to move from not working with professionals on improving their illnesses and their lives, to collaborating with professionals, to needing us less and less as they get more non-professionals in their lives. We’d also expect them to build their skills in dealing with their illness and their lives and to develop connections and support from their natural community as they recover.

Unfortunately, these three items are relatively hard to accurately describe, agree upon, and measure. That’s why you have to read this manual and practice a little to make sure you’re on the same page as we are. We’ve done a couple of reliability studies, one at the Village and one at Vinfen in Boston, and with a modest amount of training both sites were able to get very high rates of inter-rater and test-retest reliability. Of course, if you are trying to manipulate your data and “outsmart” the scale, it won’t be very reliable or valid.

Also, combining these three items didn’t lead to a neat linear scale. In some ways this is reassuring since recovery isn’t a neat linear process, but it does make things more complicated. Here’s a visual idea of what the 8 levels of the MORS looks like:



People move around in it, or get stuck in it, in a variety of ways, forwards and backwards, just like they do in real life.

We're proud that we made a one-page single-item assessment that takes a minute to fill out instead of some long scale that only researchers or universities have time to use. Even one page, though, adds to your work. So what is the MORS for? Why do we need it?

1. The MORS provides a picture of what your caseload and your work looks like. (See you really do have “harder” clients than your neighbor.) Over time, it also provides a picture of if they’re improving. (It is possible to achieve something worth celebrating without passing a milestone, but over time if someone is really making progress they will pass milestones.) It can identify your strengths and weaknesses. (Are you very good at engaging people or bad at losing them? Do your clients get stuck at “poorly coping, engaged” or do they tend to move on from there? Do your clients in “early recovery” move on and “graduate” or stay with you satisfied forever?)
2. The MORS provides a picture of your program overall. Who are you serving and what are your strengths and weaknesses? (Maybe you need more engagement services or re-engagement services. Maybe your community doesn’t have any supports or treatment for people outside of government supported services so hardly anyone moves from early to late recovery.)
3. The MORS can assist in service triage decisions. We create a lot of frustration and waste by mismatching our services to where people are in their recovery process because we too often create a treatment plan for their illness rather than their recovery. For example, someone may benefit from medications and DBT, but if they are “high risk, unengaged” they’ll never come for their appointments and you’ll be dealing with lots of “unexpected” walk-in crisis.
4. The MORS can help you identify what level of service other providers need to provide for them to succeed and make more targeted referrals. Someone may want to work, but because they are “poorly coping, engaged” they can’t make it through the lengthy

vocational rehabilitation process on their own. This doesn't mean they don't really want to work. It means we need to match them with employment services that include case management, sheltered workshops, or supported employment with job coaches for them to succeed.

5. The MORS can assist in creating flow in your program. Without flow caseloads go up and up, but who should be pushed? The MORS helps target people to move through and out of your program.
6. We have a dream that someday if we collect good Quality of Life Outcome data and Recovery progress data, those pesky auditors won't feel like they have to go through our charts with fine tooth combs to figure out if we're doing our jobs or not.

This guide contains more background information about the MORS and its reliability and validity, a step-by-step process to help you learn to rate people in a uniform manner, and a set of vignettes to walk you through the rating process. The MORS is not difficult to learn to use or time consuming. We hope it becomes an additional tool for you to promote recovery.



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